FOR BETTER TOMORROWS BODYWORK, LLC

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Email address: _____ Referred By: _____

Emergency Contact: _____ Phone number: _____

1. Have you ever had a professional massage? Yes No
2. Are you taking any medications or supplements? Yes No Please list: _____

   _____

   _____
3. Have you had/do you have any of the following?

_____ AIDS/HIV positive
_____ Anemia
_____ Arthritis
_____ Back/neck discomfort/injury
_____ Blood clotting disorder
_____ Cancer/malignant condition
_____ Car accidents
_____ Circulatory/heart problems
_____ COVID-19 exposure/symptoms (last 10 days)
_____ Diabetes
_____ Digestive problems
_____ Dislocations/sprains/strains
_____ Epilepsy
_____ Fainting/dizziness
_____ Fractures/bone trauma
_____ Headaches/migraines (chronic)
_____ Herniated disc
_____ High blood pressure
_____ Jaw pain/injury
_____ Muscle cramping (chronic)
_____ Nausea (chronic)
_____ Neurological conditions
_____ Numbness/tingling
_____ Recent surgeries
_____ Respiratory problems
_____ Skin conditions/irritations/lumps
_____ TB/other communicable diseases
_____ Ulcers
_____ Varicose veins
_____ Allergies: _____
_____ Are you pregnant?
_____ Have you had alcohol in the last hour?

Do you have any other medical conditions or allergies that your massage therapist should be aware of before giving you a massage? _____

I understand that massage is not a substitute for medical examinations and/or diagnosis. It is recommended that I see a physician for any physical ailments that I may have. I understand the need for the massage therapist to be aware of existing physical conditions; therefore, I have stated all my known conditions on the intake form and will update the therapist of changing conditions, and I understand that there will be no liability on the therapists part should I forget to do so. I also understand that illicit or sexual suggestive behavior, remarks, or advances made by myself will result in immediate termination of the session, and I will be liable for payment of the full scheduled appointment. Should I have to cancel my appointment for any reason, I agree to give the therapist a 24-hour notice. No shows and cancellations with less than 24 hours notice are subject to a cancellation fee of 50% of the scheduled appointment which is to be paid before future appointments can be scheduled. I understand that it is my responsibility to be on time for my appointment, and if I am late, the therapist will end the massage at the original ending time.

Signature: _____ Date: _____